GROVE CITY
ENDODONTICS INC.

Date _____ Social Sec.# _____

Name _____

Birth date _____ Nickname _____

Address_____

_____

Home Phone _____
Work/Cell Phone _____

If Dental Insurance is not in your name, list *name & birth date* of person responsible:

_____

EMERGENCY CONTACT INFO
Name_____ Phone_____
Relationship _____
Are you currently under the care of a physician? ____
If yes, explain: _____

List any drugs prescribed by a *physician or dentist*:_____

Are you pregnant or nursing? If yes, week # _____

Do you need to be pre-medicated before dental treatment? ___ Explain:_____

Have you ever had any of the following medical conditions? (check all that apply)

__ Heart Attack
__ Stroke
__ Heart Surgery
__ Pacemaker
__ Heart Murmur
__ Rheumatic Fever
__ Joint Replacement
__ High Blood Pressure
__ Low Blood Pressure
__ Tuberculosis (TB)
__ Asthma
__ Chronic Hepatitis
__ Diabetes
__ HIV/Aids
__ Sickle Cell Disease
__ Epilepsy/Seizures
__ Drug/Alcohol Abuse
__ Psychiatric problems
__ Cancer/Chemotherapy
__ Sinus Problems
__ Fever Blisters
__ Arthritis
__ Fainting Spells
__ Abnormal Bleeding/ Hemophilia

Have you ever experienced any medical conditions not listed previously? _____ If yes, please explain:

_____

Are you allergic to any of the following?

__ Penicillin __ Aspirin
__ Household Bleach __ Latex
__ Dental Anesthetics __ Codeine

Please list any other allergies:

_____

Are you currently taking or have you previously taken bisphophonate medications, such as Acotnel, Fosamax, or Zometa, within the past twelve (12) yrs? YES or NO

Please rate your anxiety level regarding today's appointment: (circle one)

NOT Anxious VERY Anxious
1 2 3 4 5

AGREEMENT

* I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical history.
* I consent to the necessary diagnostic procedures (including x-rays) to determine if root canal therapy is indicated, I will decide whether or not I wish to have treatment.
* I understand root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.
* I understand that only the root canal treatment is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, etc) will be done by my regular general dentist.
* I acknowledge full responsibility for the payment for such services and agree to pay for them in full, unless other specific arrangements are made with the office manager. I understand that my dental insurance carrier may pay less than the actual bill for services, and I am responsible for the entire fee, regardless of my insurance company's arbitrary determination of "usual and customary rates."
* I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize release of information necessary to process dental insurance.

Signature Date

* I acknowledge receipt of the included Notice of Privacy Practices for this office.

Signature Date